

October 1982

The Nursing Profession and the Right to Separate Representation

Christine Godsil Cooper

Nancy J. Brent

Follow this and additional works at: <https://scholarship.kentlaw.iit.edu/cklawreview>



Part of the [Law Commons](#)

Recommended Citation

Christine G. Cooper & Nancy J. Brent, *The Nursing Profession and the Right to Separate Representation*, 58 Chi.-Kent L. Rev. 1053 (1982).

Available at: <https://scholarship.kentlaw.iit.edu/cklawreview/vol58/iss4/6>

This Article is brought to you for free and open access by Scholarly Commons @ IIT Chicago-Kent College of Law. It has been accepted for inclusion in Chicago-Kent Law Review by an authorized editor of Scholarly Commons @ IIT Chicago-Kent College of Law. For more information, please contact jwenger@kentlaw.iit.edu, ebarney@kentlaw.iit.edu.

THE NURSING PROFESSION AND THE RIGHT TO SEPARATE REPRESENTATION

CHRISTINE GODSIL COOPER* AND NANCY J. BRENT**

INTRODUCTION

There are over one million registered nurses in the United States today.¹ Nursing as an occupation had unprofessional beginnings. Un-

* B.A., Rosary College; M.A., University of Illinois; J.D., DePaul College of Law; L.L.M., Harvard Law School; Assistant Professor, Loyola University Law School.

** R.N., B.S., Villa Maria College; M.S., University of Connecticut; J.D., Loyola University Law School; Partner, Nye, Brent & Shoenberger.

1. The American Nurses' Association [hereinafter referred to as ANA] reports that there are approximately 1.5 million registered nurses in the United States, with 988,055 actively employed in nursing. Pardue, *Translating Professional Potential Into Action*, Image, February, 1980, at 17 [hereinafter cited as Pardue]; Zimmerman, *How It Is With Nurses 32 Months After the Taft-Hartley Amendments*, in LABOR RELATIONS LAW PROBLEMS IN HOSPITALS AND THE HEALTH CARE INDUSTRY 109 (A. Knapp 1977) [hereinafter cited as Zimmerman].

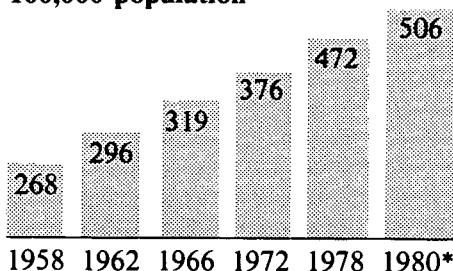
The following chart represents the employment patterns of nurses since 1958.

On duty

**Total Number Percent
registered employed employed
nurses**

1958	734,402	464,138	63.2%
1962	847,531	532,118	62.8%
1966	909,131	593,694	65.3%
1972	1,127,657	778,470	69.0%
1978	1,375,208	958,308	69.7%
1980*	n.a.	1,119,000	n.a.

**Employed nurses per
100,000 population**



*estimate

Source: American Nurses Association

til well into the nineteenth century, the nurse was untrained and uneducated.² Nursing was considered domestic service, and the many women who went into this type of work merely kept the sick clean and comfortable. It was a job of low status and little pay.

The rise of nursing as a respected and demanding profession can be traced to the influence of Florence Nightingale. Her work led directly to the establishment of schools of nursing affiliated with hospitals.³ Today nursing is recognized as a demanding profession,⁴ with

Frueudenheim, *Nurses Want More Than Aspirin for Their Pains*, N.Y. Times, Dec. 27, 1981, § 4, at 16E, col. 3 [hereinafter cited as Freudenheim].

The dropout rate of registered nurses has created a chronic shortage, which today measures about 100,000 staff nurse positions. The American Nurses Association says that over 400,000 nurses are inactive, and that 300,000 others work only part time. And applications to nursing schools are down, perhaps as a result of other careers now being open to women. *Id.* at col. 1. For an interesting study of why nurses leave nursing, see M. KRAMER, *REALITY SHOCK: WHY NURSES LEAVE NURSING* (1974).

2. J. DOLAN, *NURSING IN SOCIETY: A HISTORICAL PERSPECTIVE* (14th ed. 1978) [hereinafter cited as DOLAN]; G. GRIFFIN & J. GRIFFIN, *JENSEN'S HISTORY AND TRENDS OF PROFESSIONAL NURSING* (6th ed. 1969) [hereinafter cited as GRIFFIN & GRIFFIN].

3. See generally DOLAN, *supra* note 2; GRIFFIN & GRIFFIN, *supra* note 2; L. FLANAGAN, *ONE STRONG VOICE: THE STORY OF THE AMERICAN NURSES ASSOCIATION* (1976) [hereinafter cited as FLANAGAN]. Nightingale's early work during the Crimean War led to the establishment of the Nightingale School for Nurses in England in 1860. DOLAN, *supra* note 2, at 165-66. Ms. Nightingale's own accounts of her experience can be read in L. SEYMER, *SELECTED WRITINGS OF FLORENCE NIGHTINGALE* (1954) [hereinafter cited as SEYMER].

See also Welch, *The Organized Nurse's View*, in *LABOR RELATIONS IN HOSPITALS AND HEALTH CARE FACILITIES: PROCEEDINGS PRESENTED BY THE AMERICAN ARBITRATION ASSOCIATION AND THE FEDERAL MEDIATION AND CONCILIATION SERVICE* 41, 43 (A. Berkeley & A. Barnes eds. 1976).

4. It is well established that nurses are professional employees, as defined by the National Labor Relations Act, 29 U.S.C. § 152(12) (1976) [hereinafter cited as the NLRA]:

(12) The term 'professional employee' means—

- (a) any employee engaged in work (i) predominantly intellectual and varied in character as opposed to routine mental, manual, mechanical, or physical work;
- (ii) involving the consistent exercise of discretion and judgment in its performance;
- (iii) of such a character that the output produced or the result accomplished cannot be standardized in relation to a given period of time; (iv) requiring knowledge of an advanced type in a field of science or learning customarily acquired by a pro-

most schools of nursing located in colleges or universities.⁵ The registered nurse must pass a state licensing examination.⁶ The degree nurse holds a Bachelor of Science Degree in Nursing, or an Associate Degree in Nursing, while the three-year graduate holds a diploma from a school of nursing.⁷ Moreover, there are graduate programs leading to

longed course of specialized intellectual instruction and study in an institution of higher learning or a hospital, as distinguished from a general academic education or from an apprenticeship or from training in the performance of routine mental, manual, or physical processes; or

(b) any employee, who (i) has completed the courses of specialized intellectual instruction and study described in clause (iv) of paragraph (a), and (ii) is performing related work under the supervision of a professional person to qualify himself to become a professional employee as defined in paragraph (a).

See, e.g., *Mercy Hosp. of Sacramento, Inc.*, 217 N.L.R.B. 765 (1975), *enforcement denied*, 589 F.2d 968 (9th Cir. 1978), *cert. denied*, 440 U.S. 910 (1979); *The Presbyterian Medical Center*, 218 N.L.R.B. 1266 (1975).

In society generally, nursing now is recognized as a profession, and its importance in the delivery of health care continues to be underscored, especially in view of the shortage of physicians. See, e.g., Note, *Medico-Legal Implications of Recent Legislation Concerning Allied Health Practitioners*, 11 LOY. L.A. L. REV. 379 (1978); THE EXPANDED ROLE OF THE NURSE (M. Brown-ing & E. Lewis ed. 1973); DIVISION OF NURSING, BUREAU OF HEALTH MANPOWER, HEALTH RESOURCES ADMINISTRATION, PUBLIC HEALTH SERVICE, U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, LONGITUDINAL STUDY OF NURSE PRACTITIONERS, Phase I (March 1976), Phase II (September 1978), Phase III (May 1980).

5. See, DIVISION OF RESEARCH, NATIONAL LEAGUE FOR NURSING, NLN NURSING DATA BOOK (1978) [hereinafter cited as NLN NURSING DATA BOOK].

6. This requirement is statutorily mandated by the various Nurse Practice Acts in the respective states. In Illinois, for example, the Illinois Nursing Act, ILL. REV. STAT. ch. 111, § 3402(2) (1981) states, in pertinent part:

For the protection of life and the promotion of health, and the prevention of illness and communicable diseases, any person practicing or offering to practice professional nursing in Illinois shall submit evidence that he or she is qualified so to practice, and shall be licensed as hereinafter provided in Section 8.¹ No person shall practice or offer to practice professional nursing in Illinois or use any title, sign, card or device to indicate that such a person is practicing professional nursing unless such person has been licensed and registered under the provisions of this Act . . .

California's Nursing Practice Act is set forth in CAL. BUS. & PROF. CODE §§ 2700-2897.5 (West & Supp. 1982). The Act, at § 2732, declares that "No person shall engage in the practice of nursing, as defined in Section 2725, without holding a license which is in an active status issued under this chapter except as otherwise provided in this act . . ." (West & Supp. 1982). A state-by-state summary of Nurse Practice Acts is contained in M. CAZALAS, NURSING & THE LAW 223-30 (1978).

7. The baccalaureate nurse, as she is called, is a graduate of a four year collegiate or university program. See NLN NURSING DATA BOOK, *supra* note 5.

The A.D. nurse is a graduate of a two year program, usually based in a community college. It is possible to be a diploma nurse without having any degree; the diploma nurse may receive her training in a three year hospital program. Most hospital schools of nursing now supplement their training programs by affiliation with colleges or universities, to enable their students to receive part of their education in a university setting. See NLN NURSING DATA BOOK, *supra* note 5.

Despite the fact that all nurses sit for the same licensing examination and possess the same basic technical skills, their educational preparations differ, and thus so do their nursing abilities. The diploma graduate and the associate degree nurse, for example, are able to perform best in situations which are structured, require the utilization of routinized and standardized procedures, and where supervision is available to them. See, Yura, *Climate To Foster Utilization Of The Nursing Process*, in PROVIDING A CLIMATE FOR UTILIZATION OF NURSING PERSONNEL (1975) [hereinafter cited as Yura]; American Nurses' Association, STANDARDS FOR NURSING EDUCATION (1975) [hereinafter cited as ANA STANDARDS]. In contrast, the baccalaureate graduate is able to utilize a

the Master of Science and the Doctor of Science in nursing.⁸

Nursing has come a long way from its meager beginnings. Nonetheless, compensation for the nursing profession has not kept pace with the responsibilities exercised by this corps of highly trained and largely female⁹ workforce. Although the reasons for this lack of recognition

problem-solving approach to her client care. This problem-solving approach, also called the nursing process, utilizes a four-step approach in solving patient care problems: assessment of the data, selection of nursing interventions, implementation of the nursing interventions, and evaluation of the results of the intervention. See, H. YURA & M. WALSH, *THE NURSING PROCESS: ASSESSING, PLANNING, IMPLEMENTATION AND EVALUATING* (2d. ed. 1973). The degree nurse then functions more independently. Yura, *supra* at 21, 22; ANA STANDARDS, *supra* at 17, 23. See also D. OZIMEK, *THE BACCALAUREATE GRADUATE IN NURSING: WHAT DOES SOCIETY EXPECT?* (National League for Nursing Pub. No. 15-1520, 1974).

Because of these differences in nurse graduates, the increased health needs of the public, and the increased complexity in solving today's health care problems, the American Nurses Association in 1965 published its position paper on nurse education. In COMMITTEE ON EDUCATION, AMERICAN NURSES' ASSOCIATION, *EDUCATIONAL PREPARATION FOR NURSE PRACTITIONERS AND ASSISTANTS TO NURSES: POSITION PAPER* (1965), the ANA states that the minimum preparation for beginning professional nurse practice should be a Bachelor's Degree in Nursing, while the minimum preparation for technical nurse practice should be an Associate Degree in Nursing. *Id.* at 6-8. The professional/technical distinction in nursing has been a heated one for years. According to the ANA, only graduates of baccalaureate programs are considered professional nurses, because of their ability to problem solve and assume greater responsibilities for patient care and the prevention of illness. The three year diploma graduate, and the Associate Degree Nurse, on the other hand, are considered technically skilled but limited in their ability to practice independently. Despite the ANA's position, and the phasing out of many diploma programs in nursing since its publication, of the 988,055 R.N.'s actually working in the United States in 1979, 67% are from diploma schools, 17.5% are from baccalaureate programs, and 11.2% are Associate Degree graduates. See Pardue, *supra* note 1, at 17. The reasons for the high percentage of diploma graduates in the workforce are many. One fact is that it takes only two or three years to complete the diploma program, in contrast to a four, and sometimes five, year program to obtain a Bachelor's Degree. Another factor is that hospitals do not compensate baccalaureate graduates for their degrees. For example, in many of the large medical centers in Chicago, B.S. graduates are paid only 10-20 cents more per hour than their diploma counterparts. Other hospitals offer no difference in the hourly wage for baccalaureate graduates.

The ANA's professional-technical distinction has not received NLRB attention. The Board rarely considers the educational differences among registered nurses.

8. In the master's programs, the student can elect to major in a clinical specialty in nursing, such as psychiatry or obstetrics, or can focus on developing expertise in nursing administration or education. The Doctoral programs offer either a major in nursing or a major in a related field, such as sociology, psychology, or anthropology. In 1977, eight educational institutions offered a major in nursing only, eight offered a major in nursing or in related fields, and seven educational institutions offered a major in related fields only. In the same year there were 114 programs leading to a Master's degree in nursing. NLN NURSING DATA BOOK, *supra* note 5, at 45-53.

9. In 1972, of the 1,127,657 registered nurses inventoried by the American Nurses' Association and the Division of Nursing of the U.S. Public Health Service, only 14,625 were male, in contrast to 1,111,206 female nurses. 1,826 of the nurses did not report their sex. AMERICAN NURSES ASS'N, *FACTS ABOUT NURSING 1976-1977*, Table I-A-12, at 14 (1977). An estimated 98% of registered nurses were women in 1980. Freudenheim, *supra* note 1, at col. 4. "Strains between nurses and hospital power structures, mostly male, often reflect 'underlying problems of male-female relations . . .'" *Id.*

For an interesting account of the impact of sexism on the development and practice of nursing, see J. ASHLEY, *HOSPITALS, PATERNALISM, AND THE ROLE OF THE NURSE* (1976) [hereinafter cited as ASHLEY].

are manifold,¹⁰ a contributing factor has been the slow growth of unionization among professional nurses. While historically nurses have been reluctant to organize or to engage in concerted activity,¹¹ collective bargaining has become accepted as a means of fulfilling nurs-

10. The comparable worth movement suggests that jobs held primarily by women pay less and impart less status precisely because they are held by women. A comprehensive report of this issue is THE BUREAU OF NATIONAL AFFAIRS, INC., THE COMPARABLE WORTH ISSUE: A BNA SPECIAL REPORT (1981). The report presents federal court developments, federal agency developments, state and local developments, union activity, interviews with experts, surveys, studies, and reports; it contains an exhaustive bibliography and table of cases. For a brief report of the issue, see Cooper, *Comparable Worth—The Issue of the '80's*, 5(2) WOMEN'S LAW REPORTER 1 (Dec. 1981) (A publication of the Committee on Women's Issues, Loyola University School of Law). For discrimination as a factor in supply and demand, see Sanborn, *Pay Differences Between Men and Women*, 17 INDUS. & LAB. REL. REV. 534 (1964); J. MADDEN, *A Survey of Empirical Studies of the Female Labor Market*, THE ECONOMICS OF SEX DISCRIMINATION 5 (1973). *Contra*. EQUAL EMPLOYMENT ADVISORY COUNCIL, COMPARABLE WORTH: ISSUES AND ALTERNATIVES (E. Livernash 1980). *Lemons v. The City and County of Denver*, 620 F.2d 228, (10th Cir.), cert. denied, 449 U.S. 888 (1980) was an unsuccessful comparable pay claim involving nurses. The Denver nurses wanted the Supreme Court to review *Lemons* because, as the lawyer for Nurse, Inc. said, "No other group of plaintiffs can make as strong a statement about historic and enforced segregation of the sexes as nurses . . . nursing is characterized by three elements—salaries which employers kept low intentionally because nurses were women; sex segregation; and 'a high degree of professional skill' " *A Story Worth Telling*, The American Nurse, Sept., 1980, at 1, col. 4.

11. See Schmidman, *Nurses and Pennsylvania's New Public Employee Bargaining Law*, 22 LAB. L. J. 725, 728-733 (1971). In general, both women and professionals have been slow to organize. Even more unlikely to organize have been women professionals. Nursing, in particular, with its devotion to the care of the sick, has largely ignored its own needs. ASHLEY, *supra* note 9, at 102.

The emphasis on self sacrifice, duty to God and man, and purity crept into the Nightingale pledge, and its recitation by graduating nursing students, then and now, set the stage for the behaviors that were expected of them:

I solemnly pledge myself before God, and in the presence of this assembly, to pass my life in purity and to practice my profession faithfully. I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug.

I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in practice of my profession.

With loyalty will I endeavor to aide the physician in his work, and devote myself to the welfare of those committed to my care.

GRIFFIN & GRIFFIN, *supra* note 2, at 63. [emphasis added] The Nightingale pledge was formulated in 1893, and was first administered to the 1893 graduating class of Farrand Training School, now Harper Hospital, in Detroit, Michigan. *Id.*

A conservative, non-assertive approach was adopted by the nursing profession in its early years. When changes took place in society in the 1890's in relation to the role of women, the profession saw itself as "social reformers" rather than "radical feminists". ASHLEY, *supra* note 9, at 96, 99. The profession's emphasis was "other-oriented;" it devoted itself to the care of the sick, and eradicated "filth and immorality in American hospitals." *Id.*

Another factor which affected the development of the personality of the nursing profession was the apprenticeship form of education, the financial dependence of nursing schools upon hospitals, and the view of nursing as a subordinate part of medical practice. *Id.* at 9, 32, 83-84. As a result, the profession and its members became passive, and these passive traits have been difficult to overcome. For example, a classic research study done in 1958 on 20,000 nurses indicated that they deferred to authority figures, such as doctors, in the hospital system, and that adherence to rules was rewarded by a certain ease in encounters with supervisors and subordinates. E. HUGHES & H. HUGHES, *TWENTY THOUSAND NURSES TELL THEIR STORY* 62-63 (1958). In addition, nurses

ing's professional responsibilities.¹² The problem facing nursing orga-

still *respond* to situations rather than *initiate* action, and do not take risks. Pardue, *supra* note 1, at 17.

Notwithstanding these residual characteristics, the profession is beginning to emphasize the importance of assertiveness, power, political awareness and self-control. See, e.g., NATIONAL LEAGUE FOR NURSING, POWER: USE IT OR LOSE IT (1977); Kalisch, *The Promise of Power*, 26 NURSING OUTLOOK 42 (1978). In addition, the characteristics of persons entering the profession are changing. The average nursing school entrant into a bachelor's degree program is likely to have been in the top one-quarter of her high school class, and comes from a family that has an income in excess of \$15,000 per year. U.S. HEALTH MANPOWER BUREAU, DIVISION OF NURSING, U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE, PRESENT AND FUTURE SUPPLY OF REGISTERED NURSES 43 (1971) [hereinafter cited as PRESENT AND FUTURE SUPPLY OF REGISTERED NURSES]. This is in contrast to a 1955 study in which families from higher socioeconomic levels looked upon nursing with disfavor, and did not want their daughters to go into the profession. COMMUNITY STUDIES, INC., PUBLIC IMAGES OF THE NURSE, PART II OF A STUDY OF THE REGISTERED NURSE IN A METROPOLITAN COMMUNITY 19-30 (August 1955). Most important, the educational process of nursing students has begun to stress self-awareness and self-identity. See V. OLESEN & V. WITTAKER, THE SILENT DIALOGUE: A STUDY IN THE SOCIAL PSYCHOLOGY OF PROFESSIONAL SOCIALIZATION (1968).

In 1896, the American Nurses' Association was established to seek standardization of the educational programs that were beginning to proliferate in the United States, and to promote laws to insure that competent nurses were providing care to the sick. Jacobi, *Foreword* to FLANAGAN, *supra* note 3, at vii. It is the same American Nurses' Association that seeks to represent registered nurses in collective bargaining.

12. By the late 1930's, the American Nurses' Association decided that the only way to effectuate control over working conditions was through collective bargaining. FLANAGAN, *supra* note 3, at 169. Even so, the ANA struggled internally with two questions in relation to collective bargaining and nursing: (1) was it professionally ethical to participate in collective bargaining? (2) If collective bargaining is acceptable to the profession, should a union or a professional society represent nursing in that process? *Id.* at 170.

In 1938, the American Nurses' Association adopted the position that collective bargaining for nurses should be conducted by the professional nurses' association. *Id.* at 171. However, the ANA did not adopt collective bargaining as an integral part of its economic security program until 1946, when the members of the ANA unanimously adopted the ANA Economic Security Program. *Id.* at 168. The purpose of the Economic Security Program was "[t]o secure for nurses, through their professional associations, reasonable and satisfactory conditions of employment which, in turn, will enable the public to secure top quality nursing service in sufficient quantity to meet the demands for such services." *Id.* at 172.

In 1950, the House of Delegates, the governing body of the ANA, adopted a no-strike policy. *Id.* at 172-73. In 1957, the ANA registered as a labor organization. ZIMMERMAN, *supra* note 1, at 105. Because the self-imposed, no-strike policy hindered the advancement of the profession's economic needs, it was abandoned in 1968. Miller, *Nurses' Right to Strike*, LABOR RELATIONS 38 (J. of Nursing Ad. ed. 1975). See also Coverage of Non Profit Hospitals Under National Labor Relations Act, 1973, Hearings on S. 794 and S. 2292 before the Subcomm. on Labor of the Senate Comm. on Labor and Public Welfare, 93d Cong., 1st Sess. 115, 116 (1973) (statement of Bonnie B. Graczyk, representing the ANA) [hereinafter cited as 1973 Senate Hearings]; Extension of NLRA to Non Profit Hospital Employees, Hearings on H.R. 11357 Before the Subcomm. on Labor of the House Comm. on Education and Labor, 92d Cong., 1st & 2d Sess. 45, 49 (1971) (statement of Muriel A. Poulin, representing the ANA) [hereinafter cited as 1971 House Hearings].

In deciding to rescind its former position, the House of Delegates stated: "The American Nurses Association supports the efforts of the state nurses' associations acting as bargaining representatives for members in taking necessary steps to achieve improved conditions, including concerted economic pressures which are lawful and consistent with the nurse's professional responsibilities, and with the public's welfare." FLANAGAN, *supra* note 3, at 263-64. In 1970, the House of Delegates abandoned the ANA's 1950 neutrality policy. No longer were nurses to "maintain a scrupulously neutral position" when their employers and non-nurses were involved in a labor dispute. Rather, nurses were urged to "continue to perform their distinct nursing duties,

nizations today is a layer of legal theory that threatens effective collective bargaining in the nursing profession. In particular, the trend in the courts of appeals of requiring that professional nurses be included in comprehensive bargaining units¹³ endangers the very exist-

but to press for action in the interest of safe patient care, to reduce the patient census by curtailing admissions or by expediting discharge and transfer to other facilities, and to coordinate activities through their local unit organizations in the SNA [State Nurses Associations]." *Id.* at 264.

The current ANA Code for Nurses (a code of ethics for nurses) stresses participation in "collective action" through the Economic and General Welfare Commission, created in 1966. ANA, Code for Nurses With Interpretive Statements 9.2 at 17 (1976). In addition, the Commission has recently sponsored a proposed resolution to be voted upon during the 1980 ANA Biennial Convention in Houston, Texas. Entitled *Reaffirming Faith and Belief in the Process of Collective Bargaining*, it proposes, among other things, that at least 20% of the association's revenues be allocated to the economic and general welfare program. The American Nurse, May, 1980, at 11, col. 2. The entire resolution reads as follows:

WHEREAS, the major characteristic of a profession is the ability of its members to control their practice,

WHEREAS, the vast majority of professional nurses function as institutional employees in the health care delivery system,

WHEREAS, the process of collective bargaining has proven a very effective tool for professional employees in achieving and retaining control over their practice and also in achieving the collateral purpose of improving their economic and general welfare,

WHEREAS, Article 9(2) of the "Code for Nurses" approves of collective action by nurses and representation by the professional association in negotiations with employers to achieve employment conditions in which professional standards of nursing practice can be implemented which are commensurate with the qualifications, functions and responsibility of nurses,

WHEREAS, ANA's state constituents as of December 1979 represent approximately 110,000 registered nurses in collective bargaining, and out of these, approximately 75,000 registered nurses are dues-paying members,

WHEREAS, most collective bargaining contracts do contain clauses providing for maintenance of membership in state nurses associations and the American Nurses' Association for the duration of contracts,

WHEREAS, such clauses significantly contribute to providing a membership base of the size deemed essential for the long-term financial viability of both the state nurses associations and the American Nurses' Association,

WHEREAS, steady and continuous growth of membership in the American Nurses' Association and state nurses associations would enhance ANA's position as the voice of nursing in health legislation designed to increase the availability, accessibility and quality of health care for the American people, and

WHEREAS, recruiting and retaining members in the American Nurses' Association and its state and local constituent associations have always been regarded as a high priority in making decisions about use and allocation of funds; therefore be it

RESOLVED, that this American Nurses' Association House of Delegates reaffirms its complete and unequivocal faith and belief in the effectiveness of the process of collective bargaining as the proper and legitimate vehicle for registered nurses realizing their professional and economic aspirations,

RESOLVED, that this House of Delegates recognize and views ANA's economic and general welfare program (functioning as supportive of, and supplementing, the state nurses associations' economic and general welfare programs) as the major ANA program for the purpose of recruiting and retaining a membership base of the size that will guarantee ANA's effectiveness in influencing the nation's health care policies, and be it

RESOLVED, that this house of Delegates directs the ANA Board of Directors to give highest priority to the economic and general welfare programs by allocating at least 20 percent of the association's revenues to this program each year."

Id.

13. See text accompanying notes 27-72 *infra*.

ence of professional nursing associations, which in turn endangers health care delivery in this country. This threat to patient care contravenes the Congressional purpose of the 1974 Health Care Amendments.¹⁴ The National Labor Relations Board, pursuant to its statutory mandate, has been steadfast in its position that registered nurses normally require separate representation. This conflict between the Board and the courts will now be examined.

THE NATIONAL LABOR RELATIONS ACT AND REGISTERED NURSES

The Health Care Amendments

The National Labor Relations Act,¹⁵ an embodiment of national labor relations policy, institutionalizes a framework for the exercise of power by and between labor organizations (unions) and employers (management). Although the National Labor Relations Board had exercised jurisdiction over nonprofit hospitals under the Wagner Act,¹⁶ the Taft-Hartley amendments to the Act¹⁷ specifically exempted these hospitals from coverage.¹⁸ To be exempt from the coverage of the NLRA means that the employees of the exempt institution have no right to form or join labor organizations, no collective bargaining rights, no right to strike and no protection against statutory unfair labor practices.¹⁹ Thus, most registered nurses were unprotected by our

14. Act of July 26, 1974, Pub. L. No. 93-360, 88 Stat. 395, *amending* National Labor Relations Act, 29 U.S.C. §§ 151-68 (1971). *See* LEGISLATIVE HISTORY OF THE COVERAGE OF NON-PROFIT HOSPITALS UNDER THE NLRA, 1974, BEFORE THE SUBCOMM. ON LABOR OF THE SENATE COMM. ON LABOR & PUBLIC WELFARE, 93d Cong., 2d Sess., S. Report No. 766, *reprinted in* [1974] 2 U.S. CODE CONG. & AD. NEWS 3946.

15. Pub. L. No. 198, 49 Stat. 449 (1935) (codified at 29 U.S.C. §§ 141-187 (1970 & Supp. 1981)).

16. The Wagner Act was the original title for what is now referred to as the National Labor Relations Act. *See* Cent. Dispensary & Emergency Hosp., 50 N.L.R.B. 393 (1943), *aff'd* 145 F.2d 852 (D.C. Cir. 1944), *cert. denied*, 324 U.S. 847 (1945).

17. Also known as the Labor-Management Relations Act of 1947, tit. 1, ch. 120, 61 Stat. 136, 29 U.S.C. §§ 141-67, 171-97 (1970).

18. Section 2(2) of the NLRA was amended to define "employer" so as to exclude "any corporation or association operating a hospital, if no part of the net earnings inures to the benefit of any private shareholder or individual." 29 U.S.C. § 152(2) (1970), (current version at 29 U.S.C. § 152(2) (Supp. IV 1974)).

19. Only "employees" of "employers," as defined in sections 2(3) and 2(2), respectively, have the rights declared in section 7 and the protections provided in section 8. 29 U.S.C. §§ 152, 157, 158 (1976). It is section 7 that is the heart of the Act, to which all other provisions are ultimately directed:

Employees shall have the right to self-organization, to form, join, or assist labor organizations, to bargain collectively through representatives of their own choosing, and to engage in other concerted activities for the purpose of collective bargaining or other mutual aid or protection, and shall also have the right to refrain from any or all of such activities. . . .

29 U.S.C. § 157 (1976).

country's basic labor laws.

When Congress exempted nonprofit hospitals from the Act's protections in 1947, it did so in the belief that these institutions were "primarily community-oriented charitable institutions which needed to avoid unionization in order to maintain low costs."²⁰ But with the growth of the health care industry, it became clear that such a deferential attitude toward the role of the hospital was an anachronism. Hospitals are big businesses needing no particular protection.²¹ Moreover, Congress became convinced that lack of unionization in the health care field was responsible for low wages and poor working conditions, which in turn had a detrimental effect on patient care.²² Thus, the 1974 Health Care Amendments expanded the scope of coverage of the NLRA by eliminating the exemption for nonprofit hospitals.²³ While the 1974 Health Care Amendments to the NLRA extended the Act's protections to employees of nonprofit hospitals, thereby covering thousands of nurses, barriers to full collective bargaining for registered nurses persist.

By the 1974 Amendments, Congress did not give wholesale coverage to hospital employees, for it was concerned that disruptive strikes would interfere with patient care.²⁴ Thus, special protections were mandated: notice requirements and time restrictions are imposed on contract negotiations.²⁵ In addition, there are special provisions aimed at the peaceful resolution of negotiation impasses.²⁶ The public interest—patient care—is served by these protections, at no significant expense to the collective bargaining rights of covered employees.

Another concern of Congress was that a proliferation of bargaining units at health care institutions would result in jurisdictional disputes and successive strikes that would seriously interfere with patient

20. Vernon, *Labor Relations in the Health Care Field Under the 1974 Amendments to the National Labor Relations Act: An Overview and Analysis*, 70 N.W.U.L. REV. 202, 203 (1975) [hereinafter cited as Vernon].

21. 120 CONG. REC. 16899 (1974). "It [the medical profession] is the largest industry by far in the United States." (remarks of Congressman Thompson).

22. Vernon, *supra* note 20, at 204 (daily ed. May 2, 1974) (remarks of Senators Cranston and Williams).

23. 29 U.S.C. § 152(2) (1970 & Supp. IV 1974). The amendments define a "health care institution" as "any hospital, convalescent hospital, health maintenance organization, health clinic, nursing home, extended care facility, or other institution devoted to the care of sick, infirm, or aged persons." National Labor Relations Act §§ 2(14), 29 U.S.C. § 152(14) (1970 & Supp. IV 1974).

24. 1973 Senate Hearings, *supra* note 12; 120 CONG. REC. 12944 (1974).

25. 29 U.S.C. § 158(d) (1970 & Supp. IV 1974).

26. 29 U.S.C. § 158(g) (1970 & Supp. IV 1974).

care. The committee report²⁷ accompanying the Health Care Amendments contained what has come to be known as the "Congressional admonition": The National Labor Relations Board is to give consideration to preventing the proliferation of bargaining units in the health care industry. Thus, where the NLRB is required to designate a unit appropriate for collective bargaining, the Congressional policy against proliferation is to be taken into account in the Board's decision.

Bargaining Unit Determinations

The Board, pursuant to a well-established policy,²⁸ certifies a separate bargaining unit of registered nurses whenever such a unit is sought. However, recent court decisions have rejected the Board's policy as contrary to the Congressional admonition.²⁹ The courts prefer that registered nurses be submerged in larger, comprehensive bargaining units that include all other professional employees of health care institutions. The significance of unit determinations cannot be overstated.

The Board's bargaining unit determinations fundamentally fashion labor relations. The unit determination delimits the scope of successful union organization. Initially, the unit determination will resolve whether there will be a representation election, since a union must, as a prerequisite to gaining an election, make the statutory showing of interest.³⁰ If fewer than thirty percent of the employees in the appropriate bargaining unit have shown an interest in an election, one will not be held.³¹ However, if an election is to be held, the voters will be only those persons holding the jobs that constitute the appropriate bargaining unit.³² Thus, the unit determination influences union victory or defeat. Finally, the scope of the unit affects the union's bargain-

27. S. REP. NO. 766, 93d Cong., 2d Sess., *reprinted in* [1974] 2 CONG. CODE & AD. NEWS 3946, 3950.

28. *See, e.g.*, Allegheny General Hosp., 239 N.L.R.B. 872 (1978); St. Francis Hosp. of Lynwood, 232 N.L.R.B. 32 (1977) *enforcement denied*, 601 F.2d 404 (9th Cir. 1979); Methodist Hosp. of Sacramento, Inc., 223 N.L.R.B. 1509 (1976); Mercy Hosp. of Sacramento, Inc., 217 N.L.R.B. 765 (1975), *enforcement denied*, 589 F.2d 968 (9th Cir. 1978), *cert. denied*, 440 U.S. 910 (1979); Dominican Santa Cruz Hosp., 218 N.L.R.B. 1211 (1975).

29. Presbyterian St. Luke's Medical Center v. NLRB, 653 F.2d 450 (10th Cir. 1981); Beth Israel Hosp. v. NLRB, 107 L.R.R.M. 3214 (10th Cir. 1981); St. Anthony Hosp. Sys. v. NLRB, 655 F.2d 1028 (10th Cir. 1981); NLRB v. St. Francis Hosp. of Lynwood, 601 F.2d 404 (9th Cir. 1979).

This conflict between the Board and the courts over the issue of health care unit determinations was noted in a recent address by Board Chairman Van deWater as a significant policy issue pending before the Board. Address by Chairman Van deWater, American Bar Association Annual Meeting (Aug. 10, 1982), *reprinted in* 155 DAILY LAB. REPORTS (BNA) F-1 (Aug. 11, 1982).

30. 29 C.F.R. §§ 101.17, 101.18(a) (1981).

31. 29 C.F.R. § 101.18(a) (1981).

32. It is important to bear in mind that the unit consists of job classifications and not of

ing power vis-a-vis the employer.³³

Given the pervasive impact of unit determinations on collective bargaining, the statutory guidance given the Board in making the determination is strikingly modest. According to section 9(b),

The Board shall decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this subchapter, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof³⁴

Thus, the unit determination is to be made to assure the fullest freedom to form and join labor organizations, to bargain collectively for mutual aid and protection, or to refrain therefrom.³⁵

The scope of the unit obviously affects the employees' ability to organize. It also affects their ability to bargain. Where comprehensive units encompass employees of differing skills, attitudes, and interests, this diversity of constituency will interfere with a union's ability to adequately represent all employees in the unit. There may be serious conflicts of interest among the various employee factions. Effective communication among the diverse groups might be impossible.³⁶ None of this augers well for the union's effective negotiation or administration of a collective bargaining agreement. The employee's individual interests may be greatly diluted by submergence in the comprehensive unit.

While the comprehensive unit poses problems for the employee, a different set of problems is presented by the fragmentation of units. The smaller units are easier for the union to organize, and often harder for the employer to accept. An employer faced with numerous bargaining units must engage in numerous bargaining cycles. That entails expense. But worse for the employer is the specter of whipsaw strikes.³⁷ Fragmented units allow advantages gained by one unit's strike to accrue to the remaining units, but sparing those remaining units from the strike's economic hardships. Moreover, where the fragmented units are represented by different unions, these unions may engage in jurisdictional disputes or in work-assignment disputes.³⁸

particular individual employees. *See generally* R. GORMAN, BASIC TEXT ON LABOR LAW: UNIONIZATION AND COLLECTIVE BARGAINING 66-92 (1976) [hereinafter cited as GORMAN].

33. *Id.*

34. 29 U.S.C. § 159(b) (1976). That section gives further explicit commands pertaining to professionals, craftsmen, and security guards.

35. 29 U.S.C. § 157 (1976).

36. GORMAN, *supra* note 32, at 66-68.

37. *Id.*

38. *Id.*

Generally, unions favor small units, since these can be organized more rapidly.³⁹ The Board tends to echo this preference,⁴⁰ since a greater homogeneity of employee interests effectuates the rights guaranteed by the Labor Act, namely, the right to organize and bargain collectively.⁴¹ By preferring smaller units, the Board is fulfilling the mandate of section 9(b).

Despite this observed preference for smaller units, the Board proceeds not by analysis of size, but by analysis of the employee's "community of interest."⁴² Employees united by a significant community of interest will constitute an appropriate bargaining unit. In giving content to this rather vague standard, the Board will look to such factors as:

- (1) similarity in the scale and manner of determining earnings;
- (2) similarity in employment benefits, hours of work and other terms and conditions of employment;
- (3) similarity in the kind of work performed;
- (4) similarity in the qualifications, skills and training of the employees;
- (5) frequency of contact or interchange among the employees;
- (6) geographic proximity;
- (7) continuity or integration of production processes;
- (8) common supervision and determination of labor-relations policy;
- (9) relationship to the administrative organization of the employer;
- (10) history of collective bargaining;
- (11) desires of the affected employees; and
- (12) extent of union organization.⁴³

Extent of organization cannot be controlling, but it often has been a critical factor in unit determinations.⁴⁴

Early in the legislative hearings on the Health Care Amendments, Senator Taft expressed dissatisfaction with the Board's traditional community of interest standards as they might be applied in the hospital setting. Taft sponsored a measure that would have limited the number of bargaining units at a health care institution to the following four: professional employees, technical employees, clerical workers, and

39. *Id.*

40. *Id.* at 68.

41. 29 U.S.C. § 157 (1976).

42. See generally GORMAN, *supra* note 32, at 66-92; J. ABODEELY, R. HAMMER & A. SANDLER, *THE NLRB AND THE APPROPRIATE BARGAINING UNIT* (1981) [hereinafter cited as ABODEELY].

43. See generally GORMAN, *supra* note 32, at 66-92; ABODEELY, *supra* note 42, at 11-83.

44. 29 U.S.C. § 159(c)(5) (1976). See *NLRB v. Metropolitan Life Ins. Co.*, 380 U.S. 438, 442 (1965).

service and maintenance employees.⁴⁵ This proposal would not allow a separate unit of registered nurses; they could be included only in a comprehensive professional unit. Senator Taft's bill was replaced⁴⁶ by a compromise measure, which was devoid of any express command concerning the number or even the types of bargaining units to be established in health care institutions. However, the reports of the Senate and the House which accompanied the successful bill contained the following admonition:

EFFECT OF EXISTING LAW BARGAINING UNITS

Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry.⁴⁷

According to Senator Taft, the two policy considerations support-

45. 1973 Senate Hearings, *supra* note 12, at 4-16.

46. 120 CONG. REC. 12944 (1974).

47. S. REP. NO. 766, 93d Cong., 2d Sess., *reprinted in* [1974] 2 CONG. CODE & AD. NEWS 3946, 3950. Senator Taft's comments are instructive:

I believe this is a sound approach and a constructive compromise, as the Board should be permitted some flexibility in unit determination cases. I cannot stress enough, however, the importance of great caution being exercised by the Board in reviewing unit cases in this area. Unwarranted unit fragmentation leading to jurisdictional disputes and work stoppages must be prevented.

The administrative problems from a practical operation viewpoint and labor-relation viewpoint must be considered by the Board on this issue. Health-care institutions must not be permitted to go the route of other industries, particularly the construction trades, in this regard.

In analyzing the issue of bargaining units, the Board should also consider the issue of the cost of medical care. Undue unit proliferation must not be permitted to create wage "leapfrogging" and "whipsawing." The cost of medical care in this country has already skyrocketed, and costs must be maintained at a reasonable level to permit adequate health care for Americans from all economic sectors.

The committee, in recognizing these issues with regard to bargaining unit determination, took a significant step forward in establishing the factor of public interest to be considered by the Board in unit cases.

120 CONG. REC. 12944-45 (1974). *See also* comments of Senator Taft just prior to the law's passage, 120 CONG. REC. 13559 (1974). The comments of co-sponsor Congressman Ashbrook are enlightening:

[W]ith regard to the question of bargaining units, the committee was quite concerned with the issue of *undue* proliferation of bargaining units and by language in the committee report has stressed the need for the Board to curtail *such* proliferation in health care institutions. In the past, as illustrated by Board decisions cited in the committee report, the Board has acted at its discretion in a congressionally approved manner. However, I would expect the Board to be cognizant of the concerns for patient care and employee rights in the Board's continuing review of bargaining unit questions in the health care institutions. [emphasis supplied].

120 CONG. REC. 22949 (1974).

Senator Williams' remarks are perhaps most instructive, emphasizing the Board's statutory function:

[T]he National Labor Relations Board has shown good judgment in establishing appropriate units for the purposes of collective bargaining, particularly in wrestling with units in newly covered industries. While the Board has, as a rule, tended to avoid an unnecessary proliferation of collective bargaining units, sometimes circumstances require that there be a number of bargaining units among nonsupervisory employees, particularly

ing the admonition are public access to uninterrupted health care and cost containment in the health care industry.⁴⁸ The critical question is: Does this admonition, in light of its policy and law, destroy or complement the Board's traditional method of determining appropriate bargaining units? It is the tension between the Board's traditional function and the Congressional admonition that has been the source of much controversy in unit determinations for registered nurses.

DISAGREEMENT BETWEEN BOARD AND COURTS

Shortly after the effective date of the Health Care Amendments, the Board was called upon to determine whether a separate unit of registered nurses would constitute an appropriate unit, given the Congressional apprehension of undue proliferation. In *Mercy Hospitals of Sacramento, Inc.*,⁴⁹ the Board instituted its policy of allowing separate representation to the nursing profession in the newly covered hospitals.

[W]e have concluded that registered nurses possess . . . interests evidencing a greater degree of separateness than those possessed by most other professional employees in the health care industry. These distinct interests derive not only from the peculiar role and responsibilities of registered nurses in the health care industry, but also from an impressive history of exclusive representation and collective bargaining.

The primary and indeed overriding responsibility of registered nurses is to maintain the best possible patient care. Pursuant to this responsibility, registered nurses, unlike most other professional employees, are required to be on duty 24 hours a day, 7 days a week, 365 days a year. Their duties and responsibilities with respect to patient care cannot by law and licensure be delegated to any other employees, including other professionals, and must therefore be performed exclusively by registered nurses. Apparently in recognition of this unique degree of professional responsibility, the Joint Committee on Accreditation of Hospitals, as well as the laws of several States, requires all member hospitals to maintain a separately administered department of nursing, under the direction of a director

where there is such a history in the area or a notable disparity of interests between employees in different job classifications.

While the committee clearly intends that the Board give due consideration to its admonition to avoid an undue proliferation of units in the health care industry, it did not within this framework intend to preclude the Board acting in the public interest from exercising its specialized experience and expert knowledge in determining appropriate bargaining units.

120 CONG. REC. 22575 (1974).

Moreover, during hearings on this legislation, Congress was advised that under existing state and federal law, RN's were normally accorded the right to separate representation. 1971 *House Hearings*, *supra* note 12, at 48, 59, 67-68 (statement of Muriel A. Poulin, representing the ANA).

48. See text accompanying notes 25-28 *supra* and notes 81-90 *infra*.

49. 217 N.L.R.B. 765 (1975).

of nursing, for the purpose of establishing and administering all departmental regulations and qualifications. Thus, complete authority over registered nurses in hospitals is centralized in the director of nursing and all hiring, firing, and regulating of working conditions, such as hours, shifts, and job descriptions, take place within the confines of the department of nursing.

We also note that all registered nurses, in addition to graduating from accredited nursing schools, are required, as a precondition of employment, to take and pass uniform national licensing examinations and to acquire and maintain state licenses to practice.

Perhaps of the greatest significance in establishing the separate interests of registered nurses is their singular history of separate representation and collective bargaining often as the result of voluntary recognition.

Accordingly . . . we find that registered nurses, if they are so sought and they so desire, are entitled to be represented for the purposes of collective bargaining in a separate bargaining unit.⁵⁰

As for the other professional groups at the hospital, the Board was unwilling to find that they possessed a need for separate representation.⁵¹ The Board recognized the difference, "both functional and educational," among the various groups of non-nurse professional employees, but feared that granting separate representation would result in "undue proliferation."⁵² The diverse professional groups were united by their professionalism, and unlike registered nurses, had no history of separate bargaining.⁵³

In subsequent unit determinations, beginning with *Methodist Hospital of Sacramento, Inc.*,⁵⁴ the Board found units consisting solely of registered nurses to be appropriate, while residual professional employees constituted yet another appropriate unit. The reaction in the courts was that the Board's practice amounted to a per se rule, or an irrebuttable presumption concerning these units.

In *NLRB v. St. Francis Hospital of Lynwood*,⁵⁵ the court stated that the Board's per se policy of separate representation for nurses was inconsistent with the Congressional admonition against unit proliferation.

The Methodist-Mercy precedent contravenes that congressional ad-

50. *Id.* at 767.

51. *Id.* at 768-69.

52. *Id.* at 769.

53. *Id.*

54. 223 N.L.R.B. 1509 (1976); *Doctor's Community Hosp. of Victor Valley*, 220 N.L.R.B. 977, 977-78 (1975) ("we are mindful of the congressional concern for the undue proliferation of bargaining units, but find, nevertheless, that the singularity of interest possessed by registered nurses compels recognition.").

55. 601 F.2d 404 (9th Cir. 1979).

monition by establishing an irrebutable presumption in favor of certain units. While Congress did not pass S.2292 which would have set up a uniform four unit limit for all non-profit hospitals, that failure does not sanction the Board's establishment of its own more extensive five unit standard, especially in the fact [*sic*] of contrary language from Congress.⁵⁶

The court went on to acknowledge that a separate unit composed exclusively of registered nurses may, at times, have validity. But the court insisted that the Board make a proper determination by hearing all the facts, including those presented by employers, and by indicating how the unit determination implemented the congressional admonition.⁵⁷

Moreover, the *St. Francis* decision criticized the Board's community of interest analysis, calling instead for a standard of *disparity* of interests.⁵⁸ The court's conclusion was based on statements in the legislative history.⁵⁹ Finally, the court noted that the "traditional factor of community of interests [must] be subordinated to the directive against undue proliferation."⁶⁰ Following these conclusions, the court undertook a separate analysis of the disparity of interests between nurses and the remaining health care professionals.⁶¹ Although the court acknowledged that it did not have the power to make unit determinations,⁶² thus making remand necessary, the court did suggest that there was no real disparity of interests between the different professional groups of employees.⁶³

Following the *St. Francis* decision, the Board reevaluated its policy of granting separate representation to registered nurses. In *Newton-Wellesley Hospital*,⁶⁴ it disavowed any attempt at establishing or maintaining an irrebuttable presumption on the appropriateness of registered nurse units. Of particular importance is the way in which the Board reconciled this result with its statutory mandate: "Such a per se approach to unit determinations is inconsistent with the Board's Section 9(b) responsibility to decide in each case whether the requested unit is appropriate."⁶⁵ The Board then went on to acknowledge that it

56. *Id.* at 414.

57. *Id.* at 416.

58. *Id.* at 418-19.

59. *Id.*

60. *Id.* at 419.

61. *Id.* at 418-20.

62. *Id.* at 420.

63. *Id.* at 419-20.

64. 250 N.L.R.B. 409 (1980).

65. *Id.* at 411.

must attend to the Congressional admonition.⁶⁶ However, the Board disagreed with the *St. Francis* command to consider disparity of interests; this, said the Board, it already does. Characterizing the difference between the "community of interest" analysis and the disparity analysis as "semantic,"⁶⁷ the Board explained that it always, implicitly at least, determines "whether the interests of the group sought are sufficiently distinct from those of other employees to warrant the establishment of a separate unit."⁶⁸ The Board was resolute:

The Board herein unanimously reiterates the opinion first expressed in *Mercy Hospital* that, giving full and due regard to the legislative history of the health care amendments, registered nurses can, and in this case do, possess such a community of interests as makes their separate representation appropriate.⁶⁹

Although numerous Board⁷⁰ and court⁷¹ decisions have been rendered since the seminal *Newton-Wellesley* and *St. Francis* cases, the Board's position has not changed substantially from those authorities. The Board continues to find registered nurse units appropriate in most cases,⁷² but refuses to hold such units per se appropriate.⁷³ The courts

66. *Id.*

67. *Id.*

68. *Id.*

69. *Id.* at 413.

70. *E.g.*, Addison-Gilbert Hosp., 253 N.L.R.B. 1010 (1981); Mount Airy Foundation, 253 N.L.R.B. 1003 (1981); Frederick Memorial Hosp., Inc., 254 N.L.R.B. No. 2 (1981); Doctors' Hosp. of Montclair, 254 N.L.R.B. No. 175 (1981); Nat'l Medical Convalescent of San Diego, 254 N.L.R.B. No. 163 (1981); Brookwood Hosp. Mgmt. Corp., 252 N.L.R.B. 748 (1980).

71. *Presbyterian/St. Luke's Medical Center v. NLRB*, 653 F.2d 450 (10th Cir. 1981); *Beth Israel Hosp. v. NLRB*, 107 L.R.R.M. 3214 (10th Cir. 1981); *St. Anthony Hosp. Sys. v. NLRB*, 655 F.2d 1028 (10th Cir. 1981).

The United States Court of Appeals for the Tenth Circuit has granted the NLRB's motion for *en banc* reconsideration of the *Beth Israel* and the *St. Anthony* decisions. The basis for the NLRB's motion was that the court had misconstrued the applicability of the Federal Rules of Evidence to the bargaining unit determination. *Beth Israel & Geriatrics Center v. NLRB*, No. 80-1942 (10th Cir., Jan. 5, 1982); *St. Anthony Hosp. Sys. v. NLRB*, No. 80-1968 (10th Cir., Jan. 5, 1982); reported in No. 15 Daily Labor Reports (BNA) at A-1, Jan. 22, 1982. In each of these cited tenth circuit cases, the court has held that "application of the presumption [in favor of the registered nurses unit] violated FED. R. EVID. 301 inasmuch as it relieved General Counsel of his burden to establish by a preponderance of the evidence that an unfair labor practice has occurred." *Beth Israel Hosp. v. NLRB*, 107 L.R.R.M. 3214, 3215 (10th Cir. 1981). Although this issue is beyond the scope of this paper, it is difficult to imagine how the court allowed FED. R. EVID. 301, which is appropriate in an unfair labor practice proceeding, pursuant to Section 10(b) of the NLRA, 29 U.S.C. § 160(b), to be applied to a unit determination. Unit determinations are not governed by the Federal Rules of Evidence. NLRB, RULES AND REGULATIONS AND STATEMENTS OF PROCEDURE, 102.66(a) (series 8, Part 102) (1959) (amended 1961).

The American Federation of Teachers has filed a petition for certiorari with the Supreme Court in *Presbyterian/St. Luke's Medical Center v. NLRB*, 653 F.2d 450 (10th Cir. 1981), reported at No. 15 DAILY LAB. REPORTS (BNA) at A-1, Jan. 22, 1982.

72. In *Mount Airy Foundation*, 253 N.L.R.B. 1003 (1981), the Board included non-nurse professionals in the nurses' unit. This was because of the unique features of the psychiatric institution: there the nurses and the professionals with masters' degrees in psychology or related fields

generally believe that the Congressional admonition dictates their inclusion in a comprehensive professional unit. These positions will be evaluated in the next section of this article.

LEGAL STATUS OF THE ADMONITION

The Board admits that it must make an accommodation to the admonition.⁷⁴ The Court of Appeals for the Ninth Circuit believes that the admonition requires a subordination of the traditional community of interest analysis.⁷⁵ Rarely is the legal effect of the admonition given any serious attention. The admonition is not part of the legislation forming the Health Care Amendments. Rather, it is but a statement in a report accompanying the legislation.⁷⁶ The Health Care Amendments themselves make no provisions concerning the number or type of

all had work assignments that focused on the psychological rather than the physical needs of the adolescents in their care. Since any residual professional unit would have been small, the Board designated a comprehensive unit:

Faced with the choice of creating a residual unit of only nine nonnurse professionals or of including them in a unit with the registered nurses and the team leaders with master's degrees, we find that the latter is more consistent with the purposes of the Act.

Id. at 1006.

The nine who would have constituted a residual unit consisted of two pharmacists, two occupational therapists, four social workers, and one educator. The number of nurses in the petitioned-for unit was fifty-two, the number of team leaders included with the nurses was six. The significance of the numbers was explained:

where a substantial portion of nonnurse professionals (the team leaders with master's degrees) must be included with the registered nurses [because they "perform virtually the same daily tasks, substitute for each other, receive the same benefits, and are subject to the same supervision" *id.*], and where such a combined unit comprises the vast majority of the Employer's professionals, it is appropriate that the small remainder of disparate residual professionals be included in the unit as well.

Id. at 1006-07. See also *Family Doctor Medical Group*, 226 N.L.R.B. 118 (1976). Where appropriate, the Board can, with the approval of the employees, place registered nurses in comprehensive professional units. *Id.* at 121.

73. *Beth Israel Hosp. v. NLRB*, 107 L.R.R.M. 3214, 3216 (10th Cir. 1981); *Presbyterian/St. Luke's Medical Center v. NLRB*, 653 F.2d 450, 455-56 (10th Cir. 1981).

74. *Newton-Wellesley Hosp.*, 250 N.L.R.B. 409, 412 (1980). The Board earlier took the view that the admonition was to constitute an additional factor in unit determinations. *Shriner's Hosp. for Crippled Children*, 217 N.L.R.B. 806, 808 (1975).

It should be emphasized that the admonition refers to "due" consideration, a standard which acknowledges the existence of other considerations. It is not a standard requiring inattention to all other considerations.

75. *NLRB v. St. Francis Hosp.*, 601 F.2d 404, 419 (9th Cir. 1979).

Several courts have been critical of the Board for failure to give due consideration to the admonition. *Mary Thompson Hosp. v. NLRB*, 621 F.2d 858 (7th Cir. 1980); *Allegheny Gen. Hosp. v. NLRB*, 608 F.2d 965 (3rd Cir. 1979); *NLRB v. Mercy Hosp. Ass'n*, 606 F.2d 22 (2d Cir. 1979), *cert. denied*, 445 U.S. 971 (1980); *NLRB v. W. Suburban Hosp.*, 570 F.2d 213 (7th Cir. 1978); *St. Vincent's Hosp. v. NLRB*, 567 F.2d 588 (3rd Cir. 1977). It is sometimes said that the traditional analysis for unit determinations is not appropriate for the health care industry. *St. Vincent's Hosp. v. NLRB*, 567 F.2d 588, 592 (3d Cir. 1977) (court admonished NLRB that the standards for bargaining units in other industries "do not follow the blueprint Congress desired in a hospital").

76. See note 47 *supra*.

bargaining units in the health care industry. Moreover, the Amendments made no change in any portion of the NLRA dealing with bargaining unit determinations; there were no provisions amending Section 9 of the Act, the statutory authority for Board representation proceedings. Thus, as recognized by Judge Fairchild in *Mary Thompson Hospital, Inc. v. NLRB*,⁷⁷ the admonition is merely hortatory, forming no part of the legislation:

Under the circumstances, the "admonition" and the Board's response to it seem to be a matter between the Board and Congress. If the Board may be thought by members of Congress to pay insufficient heed to the "admonition," the Board may be courting a statutory change. But it seems to me that the "admonition" is not appropriate for application by the courts in deciding whether an order of the Board conforms to the statute or whether the Board has abused the discretion conferred on it by statute.⁷⁸

The Health Care Amendments extended coverage to hospital employees by deleting the non-profit hospital exemption contained in section 2 of the National Labor Relations Act; the Amendments redefined "employer." The Amendments also directly affect notice requirements for collective bargaining and for strike activity. The Amendments in no way redefine the Board's function in making unit determinations, nor do they, directly or indirectly, reformulate "unit appropriate for collective bargaining." In fact, the Board's traditional function and good judgment in making bargaining unit determinations is supported by the need to give a liberal construction to this labor legislation in order to effectuate its remedial purposes,⁷⁹ namely, the extension of section 7 rights to hospital employees.

Thus, aggressive judicial review of the weight given by the Board to the Congressional admonition is misplaced. The Board's unit determinations can hardly be "arbitrary and capricious,"⁸⁰ the standard of review for unit determinations, when it gives great weight, little weight, or no weight at all to an admonition that is without any legal effect.

77. 621 F.2d 858, 864 (7th Cir. 1980) (Fairchild, C.J., dissenting).

78. *Id.*

79. The Tenth Circuit has acknowledged this canon of construction. *Presbyterian/St. Luke's Medical Center v. NLRB*, 653 F.2d 450, 455 (10th Cir. 1981) ("We recognize that labor legislation should normally be construed liberally.").

80. This is the standard of review for Board unit determinations even in the Tenth Circuit, a court that has been particularly critical of Board unit determinations in the health care industry. *NLRB v. Dewey Portland Cement Co.*, 336 F.2d 117, 119 (10th Cir. 1964). Courts of appeals are normally deferential to Board unit determinations. See GORMAN, *supra* note 32, at 79-80. The Supreme Court has used a standard of "so unreasonable and arbitrary as to exceed the Board's power." *Packard Motor Car Co. v. NLRB*, 330 U.S. 485, 491 (1947).

Although this issue could end the entire inquiry, discretion requires that alternative evaluations be given.

POLICY AGAINST PROLIFERATION

Senator Taft was particularly concerned about the dangers of proliferation. He noted the policy considerations informing the Congressional directive: cost containment in the health care industry; and the minimization of strikes in hospitals, so as to insure, to the extent possible, uninterrupted health care.⁸¹

Cost containment is the least tenable consideration, since one important rationale for extending NLRA coverage to non-profit hospitals was the belief that low wages interfered with quality patient care.⁸² To the extent that nonproliferation is intended to reduce costs by discouraging unionization (larger units are more difficult to organize), that intention is contrary to the direction of the Health Care Amendments. The Amendments give section 7⁸³ rights to previously excluded employees. To the extent that nonproliferation is intended to reduce costs by minimizing the cost of negotiating and administering collective bargaining agreements, the policy deserves consideration. Accordingly, we will discuss whether allowing separate representation to nurses will cause undue proliferation, resulting in burgeoning costs.

To allow separate representation to registered nurses is to designate two rather than one professional unit. Taft's original, defeated, proposal countenanced only one professional bargaining unit in the health care industry. Since this proposal was unsuccessful, being substituted by the Congressional directive, moving one increment away from the one professional unit, by allowing two professional units, does not amount to proliferation. If Congress had considered that to be proliferation, it never would have defeated Taft's proposal. Since professional employees have a statutory right to be represented in an all-professional unit, where they desire such representation,⁸⁴ the only issue is how many professional units constitute undue proliferation.

The Board's normal practice is to designate two professional units: one composed of registered nurses, and the other composed of the

81. See note 47 *supra*.

82. See *Vernon*, *supra* note 20, at 203-04. See also *Beth Israel Hosp. v. NLRB*, 437 U.S. 483, 497-98 (1978).

83. 29 U.S.C. § 157 (1976). See Note 19, *supra* for the text of this section.

84. 29 U.S.C. § 159(b)(1) (1976) provides as follows: "[T]he Board shall not (1) decide that any unit is appropriate for such purposes if such unit includes both professional employees and employees who are not professional employees unless a majority of such professional employees vote for inclusion in such unit."

residual, non-nurse professional employees.⁸⁵ It is rare indeed for the Board to determine that more than two professional units are appropriate.⁸⁶ The Board itself has observed that the number of appropriate units is very limited.⁸⁷

Therefore, to recognize that there are normally two appropriate, professional units in the health care industry is to present hospital employers with but one additional round of bargaining, and with but one additional contract to administer. This one additional unit cannot cause costs to soar, in contravention of the Congressional policy.

The minimization of disruptive strikes is a very serious consideration. The fragmentation of units poses the danger of numerous strikes in hospitals. Since health care is not storable, and is often a life-or-death matter, care must be taken that hospital strikes are less prevalent and less protracted than in other industries. A policy of granting separate representation to registered nurses will not increase the frequency or duration of hospital strikes. Until 1968, the American Nurses Association had a self-imposed, no-strike policy.⁸⁸ Nurses rarely engage in strike activity.⁸⁹ Although registered nurses are entitled to be con-

85. See notes 70 & 72 *supra*. The Board was attentive to nonproliferation even before the admonition. See *Extendicare of W. Va., Inc.*, 203 N.L.R.B. 1232, 1233 (1973) (petition for units denied as creating "unwarranted unit fragmentation").

86. The Board recognizes that physicians could constitute a separate unit. See *Ohio Valley Hosp. Ass'n*, 230 N.L.R.B. 604 (1977); *New York Univ. Medical Center*, 217 N.L.R.B. 522 (1975). But see *Newton-Wellesley Hosp.*, 250 N.L.R.B. 409, 413-14 (1980). For the view that a registered nurse unit constitutes proliferation, see Shepard, *Health Care Institution Labor Law: Case Law Developments, 1974-78*, 4 AM. J. L. & MED. 1 (1978).

87. *Newton-Wellesley Hosp.*, 250 N.L.R.B. 409, 415 n.21 (1980).

88. See note 12 *supra*.

89. Studies done in 1967 and 1968 indicate that in cities where there is greater union activity, there is greater possibility of a strike being averted; agreements were reached without resort to strikes. See PRESENT AND FUTURE SUPPLY OF REGISTERED NURSES, *supra* note 11, at 17.

During the 1967 and 1968 time period, there were a total of nineteen "job actions" by nurses reported across the country in various cities. Of those nineteen job actions, ten were actually carried out. The remaining nine, all of which concerned the issue of better salaries for the 1800-plus registered nurses involved in the action, were resolved by settlement with the help of union intervention. *Id.* at 17-18 (Table 5).

Nurses are more likely to strike for recognition than for wages. The nurses at Newton-Wellesley Hospital in Massachusetts, by nearly a 2-1 margin, voted to strike for recognition. They struck on May 28, 1980 because they believed that an NLRB ruling on the appropriateness of an all-registered nurses bargaining unit would take years. The strike ended June 16, 1980, when the hospital agreed to recognize the Massachusetts Nurses' Association. Both sides agreed to abide by the forthcoming NLRB bargaining unit determination. Less than one month later the Board issued its ruling in *Newton-Wellesley Hosp.*, 250 N.L.R.B. 409 (1980). 77 CHART 5 (Sept. 1980) (CHART is the official publication of the Illinois Nurses' Association).

See also 1973 Senate Hearings, *supra* note 12, at 113-14 (statement of Bonnie P. Graczyk, representing the ANA); 1973 Senate Hearings, *supra* note 12, at 193-94, 209-15 (statements of William M. Whelan, representing the California Hospital Association); 1971 House Hearings, *supra* note 12, at 188-92; 1971 House Hearings, *supra* note 12, at 115, 117 (statement of Lionne Conta, representing the CNA).

cerned about their own economic well-being, their tradition is to emphasize patient care.⁹⁰

In summary, designating two professional units, rather than one, does not constitute proliferation at all. Even less does it constitute undue proliferation. Moreover, separate representation of nurses supports the policy behind the Congressional admonition, namely cost containment and the curtailment of strike activity.

DISPARITY OF INTERESTS

It can be demonstrated that registered nurses normally share a community of interests that is significantly disparate from the interests of other health care professionals. This demonstration is not meant to "generalize[] the working conditions of all registered nurses and their history of collective bargaining in every non-profit hospital throughout this country,"⁹¹ but is meant to suggest the unique features of the nursing profession, and to relate the unique needs of the nursing profession to our national labor policy.

Health care institutions employ a myriad of different professionals: physicians, pharmacists, social workers, medical laboratory technologists, occupational therapists, physical therapists, dieticians, radioisotope technologists, chemists, nuclear medicine technologists, biomedical engineers, laboratory technologists, rehabilitation therapists, and registered nurses come to mind.⁹² To separate each professional group into a separate bargaining unit would undoubtedly disturb Senator Taft as well as contravene the Congressional intent expressly informing the Health Care Amendments, namely, non-proliferation.

Since registered nurses comprise the largest group of health care professionals, the department of nursing is typically the largest department in any hospital.⁹³ It is the registered nurse, of all health care professionals, who has the most direct and constant contact with patients. The nurse constantly monitors patient needs, coordinates the work of other health professionals, and thereby assures that continuity of patient care is maintained.⁹⁴

90. See notes 11 & 12 *supra*.

91. NLRB v. St. Francis Hosp. of Lynwood, 601 F.2d 404, 415 (9th Cir. 1979).

92. These occupations are commonly considered professional under the NLRA. See *generally* Mount Airy Foundation, 253 N.L.R.B. 1003, 1005 n.7 (1981).

93. Newton-Wellesley Hosp., 250 N.L.R.B. 409, 414 (1980).

94. Newton-Wellesley Hosp., 250 N.L.R.B. at 410. Extension of NLRA to Nonprofit Hospital Employees, Hearings on H.R. 1236 Before the Special Subcomm. on Labor of the House Comm. on Education and Labor, 93d Cong., 1st Sess. 16, 16-17, 19-21 (1973) [hereinafter cited as *1973 House Hearings*] (statement of Charles E. Hargett, representing the ANA).

All nurses possess certain basic technical skills which are vital to carrying out routine nursing care, such as performing injections, changing dressings, using sterile technique, preparing medications, and performing catheterizations. Moreover, under various nursing state practice acts, nurses are required to assume responsibility for exercising independent judgment and discretion in patient care.⁹⁵

Modern patient care in large metropolitan hospitals typically involves a "team" approach. For example, optimal patient care requires cooperation between the physician, the nurse, the physical therapist, the dietitian, and other professionals as well. This multi-disciplinary approach is mandated by the advanced state of medical technology and knowledge, which has resulted in increasing specialization by the various health care professionals. Thus, the development of nursing and other specialties has meant that the degree of interdependence among the professions has increased. It is frequently the nurse's professional discretion that determines whether the needs of the patient require the summoning of a more specialized or different professional. The registered nurse has peculiar authority in dealing with other health care employees. It is the nurse who has a comprehensive and constant overview of the patient's needs and who assures coordination of patient care.

A team approach also includes various non-professional, or technical, members, such as nursing aides and practical nurses. It is the registered nurse who evaluates whether adequate care has been given by technical employees, and it is the registered nurse who evaluates whether medical directives have been carried out appropriately and whether records are adequately maintained in order that the continuity of care can be assured, despite shifts in personnel.⁹⁶ No other health care professional has such direct and constant patient care responsibilities.⁹⁷

Hospitals, in an effort to avoid bargaining, contend that nurses have no disparity of interests with other health care professionals.⁹⁸ In

95. See note 6 *supra*.

96. See generally *Newton-Wellesley Hosp.*, 250 N.L.R.B. at 410.

97. *Id.* at 413-14.

98. See Brief for Respondent, *NLRB v. St. Francis Hosp. of Lynwood*, No. 78-1048 (9th Cir. 1980); Brief for Petitioner, *Presbyterian/St. Lukes Medical Center v. NLRB & St. Luke's Federation of Nurses & Health Professionals*, No. 80-1426 (9th Cir. 1980). The Tenth Circuit has accepted this view. *Presbyterian/St. Luke's Medical Center v. NLRB*, 653 F.2d 450 (10th Cir. 1981).

For a view of hospitals as union busters, see LaViolette, *Union busters, out-of-touch organizers slow healthcare unionization*, 10 Mod. Healthcare 66 (Sept. 1980). See generally *St. Francis Hosp. & Mod. Management, Inc.*, 28 DAILY LAB. REPORTS D-1 (Feb. 10, 1982). See also Baird, *Barriers to Collective Bargaining in Registered Nursing*, 20 LAB. L. J. 42 (1969); Osterhaus,

this connection, the hospitals strongly emphasize the many specialties in nursing, and the frequent contact which specialty nurses have with other health professionals in their specialties.

This view does not acknowledge the unique role of the professional nurse. Hospital nursing involves two major activities: providing direct care to patients, and communicating with other health professionals regarding the care given.⁹⁹ When providing care to the patient, the professional nurse is constantly observing the patient and gathering information about the patient's physical and emotional state. Once this information is obtained, the nurse then makes a professional judgment about the nursing needs of the patient. Then, based on her observations and information gathered, the nurse determines what intervention is necessary.¹⁰⁰ Once she has gone through this process, she communicates that information to the other nurses¹⁰¹ and other health professionals, including the physician, and records that information in the patient's chart. Because a nurse is with the patient on a 365 day, seven days a week, twenty-four hours a day basis, other health professionals depend upon her observations and recorded and communicated information in order to make judgments about the care they are responsible for giving to the patient.¹⁰² Clearly, no other health professional pos-

The Effect of Unions on Hospital Management, 48 Hosp. Progress 68 (June 1967); Spillane, *Survey Report on Personnel Directors: Salaries, Backgrounds, Attitudes on Unions, Management, Wages, Etc.*, 47 Hosp. Progress 61 (Nov. 1966).

99. THE CLINICAL NURSE SPECIALIST: INTERPRETATIONS 9-10 (J. Riehland & J. McVay eds. 1973).

100. V. HENDERSON & G. NITE, *PRINCIPLES AND PRACTICE OF NURSING* 320 (6th ed. 1978) [hereinafter cited as HENDERSON].

101. In addition to communicating information to other health professionals, nurses also communicate information concerning patient care to each other. For example, each shift begins with the prior nursing staff's report on each patient that is on the hospital unit. Likewise, during each shift, information concerning patient care is constantly being exchanged among the nurses working on that unit.

102. To illustrate with an example of a male patient who has undergone a right leg amputation:

The nurse, when changing the patient's dressing, observes that the patient's color is flushed, determines that his body feels warm, and hears the patient complain of not feeling well. The nurse immediately takes the patient's temperature; the thermometer reads 101° Fahrenheit. The nurse then immediately contacts the physician and informs him of her observations, the patient's complaints, and his temperature. The physician arrives on the unit, examines the patient, and writes orders which are then carried out by the nursing staff. The nurse coordinates the implementation of the doctor's orders. The nurse, in addition to contacting the physician about the patient's condition, also records that information in the nursing notes in the patient's chart and shares that information with other nurses on the floor during that shift. She will communicate the information to the next nursing shift during report when they come on duty.

The nurse must also communicate the information about her patient to the health professionals who come in contact with her patient. Thus, when the dietician arrives on the floor to discuss the patient's new diet, or the respiratory therapist arrives on the unit to give the patient his post-operative breathing exercises, it is the nurse who must discuss her patient's condition. The nurse

sesses this unique and central position in the health care delivery system.

The nurse's unique role affords her a commonality of interest with other nurses, regardless of specialty. Whether one is a psychiatric nurse, a pediatric nurse, or a nurse on the orthopedic unit, the common denominator shared among nurses is their close and constant proximity to the patients they care for and the vast amount of information about those patients they communicate to other health professionals. By way of illustration, nurses specializing in orthopedics have a community of interests with the physical therapists who aid in rehabilitating orthopedic patients in much the same manner that attorneys specializing in real estate have a community of interests with real estate brokers.

The commonality of interests shared by registered nurses gives rise to a distinctive interest at the bargaining table. Nurses' organizations are concerned with establishing working conditions that enable them to provide patient care consistent with their professional skills and standards. Thus, for example, the American Nurses Association has sought, through collective bargaining, to deal with patient care assignments, adequate staffing, equipment, excessive clerical tasks, inadequate support systems, and continuing education.¹⁰³ These unique needs—or community of interests, or “disparity of interests” from other health care professionals—accounts for nursing's singular history of separate collective bargaining.¹⁰⁴

also communicates the patient's expressions of concern about an artificial limb and about his need for financial assistance to the social worker who will be helping him obtain a prosthesis.

The nurse's function can be contrasted to that of other health care professionals by its holistic view. Nurses do not care for gastrointestinal systems or pulmonary functions, but rather for the total patient. *See generally*, HENDERSON, *supra* note 100; *see also* 1973 Senate Hearings, *supra* note 12, at 112, 121-22, 124; 1973 House Hearings, *supra* note 94, at 16-18, 20, 22-23.

According to a representative of St. John's Hospital and Health Center of Santa Monica, California, nurses are the “medium through which doctors provide health care,” and, accordingly, are the “fulcrum of a health care institution.” *Quoted in* 204 Daily Labor Reports (BNA) A-11 (Oct. 22, 1981).

103. The most frequent complaints of nurses, according to a recent survey of 22,750 out of New Jersey's 76,000 registered nurses, are the following:

“inability to provide quality nursing care, because of such factors as insufficient staffing; rotation to different parts of the hospital, which meant they were unable to apply their knowledge consistently, and ‘rental nurses’ (not on staff)” resulting in lack of continuity in patient care.”

Freudeheim, *supra* note 1.

As a remedy for these complaints, the National Commission on Nursing has recommended “adequate salaries, flexible scheduling patterns and involvement in decision making.” *Id.*; *see* D. ROTHMAN & N. ROTHMAN, *THE PROFESSIONAL NURSE AND THE LAW* 163 (App. I) (1977). *See also* 1973 Senate Hearings, *supra* note 12, at 111, 113, 117.

104. Mercy Hosp. of Sacramento, Inc., 217 N.L.R.B. 765, 767 (1975). Member Kennedy's dissent in this decision noted that nurses' history of separate representation “is not entirely unrelated to sex consideration [*sic*].” *Id.* at 774.

The creation of comprehensive units has had a profound impact on small, specialized health care unions. The future of these specialized unions is in danger.¹⁰⁵ The American Nurses Association, the professional organization of registered nurses, commonly, through its state affiliates, seeks collective bargaining rights.¹⁰⁶ However, these professional organizations are far more than simply labor unions; the nurse associations promote continuing education for nurses and better health care for society.

Representation of registered nurses by professional nursing organizations has been a significant factor in Board determinations. Although generally phrased in terms of their "singular history of separate bargaining,"¹⁰⁷ this fact of professional representation means that the nurses' labor organization is going to be particularly responsive to community health care needs, to the nursing tradition of patient care.¹⁰⁸ This tradition of public service might be jeopardized if nurses are represented by non-nursing labor organizations.¹⁰⁹ If nurses are not accorded separate representation, their professional organizations might

105. The Board's practice of including licensed practical nurses in comprehensive technical units "has brought into question the very existence of the National Federation of Licensed Practical Nurses (NFLPN), a once flourishing union." ABODEELY, *supra* note 42, at 284.

106. The impact of the ANA bargaining can be seen throughout the country. For example, by the end of 1970, 333 contracts negotiated by thirty-two State Nurses' Associations were in force for 90,200 nurses and 471 employers. FLANAGAN, *supra* note 3, at 264. The ANA's Economic and General Welfare Program provides publications for its members concerning their rights in the collective bargaining process. State nurses' associations across the country are fighting to maintain the right to be the collective bargaining representatives for their members. *See, e.g.*, INA Defeats AFGE Bid for VA Nurses, 74 CHART 3 (April, 1980); Oregon Nurses Defeat AFT in Unit Election, *The American Nurse*, Aug. 20, 1979 at 1.

107. *See, e.g.*, *Mercy Hosp. of Sacramento, Inc.*, 217 N.L.R.B. at 767.

108. This factor has received at least implicit recognition from the Board:

Lastly, the record establishes that the Petitioner [Massachusetts Nurses Association] represents employees at 43 other health care institutions in Massachusetts which come within the coverage of the Act. In all 43 cases, the bargaining units consist solely of registered nurses.

Newton-Wellesley Hosp., 250 N.L.R.B. at 414. *See also Addison-Gilbert Hosp.*, 253 N.L.R.B. 1010 (1981).

109. The ANA and its affiliates represent more organized nurses "than all the other unions combined," according to Wayne Emerson, director of the ANA's labor relations department. LaViolette, *Schizophrenia Makes ANA Prime Target for Other Unions' Attacks* 10 MOD. HEALTH-CARE 65, 72 (Sept. 1980).

The unions representing registered nurses, and their respective numbers, follow:

go the way of other specialized health care unions.¹¹⁰ In the final anal-

UNION	HEALTHCARE WORKERS REPRESENTED BY THE UNION	NURSES REPRESENTED BY THE UNION
ANA state affiliates	110,000	107,800 (estimated)
Service Employee International Union	275,000	12,000
National Union of Hospital and Health Care Employees (1199)	100,000	6,000
Federation of Nurses and Health Professionals, a division of the American Federation of Teachers	25,000	12,500

Id. at 73.

Because nurse and nursing organizations have traditionally been reluctant to organize, traditional labor unions have begun drives to organize nurses. *Id.* at 65. "AFL-CIO unions are starting to hold as many nurse representation elections as state nurses' associations." *Id.*

110. Another threat to the future of professional nurses' organizations is the use of the supervisory exclusion in the health care industry. Because supervisors are closely aligned with management, and because management is entitled to the undivided loyalty of its supervisory staff, Congress has exempted supervisors from the statutory definition of "employees." 29 U.S.C. § 152(3), (11) (1976).

Thus supervisors are beyond the protections of the NLRA: they cannot vote in representational elections and they are not protected from management unfair labor practices. See generally Finkin, *The Supervisory Status of Professional Employees*, 45 FORDHAM L. REV. 805 (1977); Comment, *The Status of Supervisors Under the National Labor Relations Act*, 35 LOUISIANA L. REV. 800 (1975).

Head nurses are commonly viewed as supervisors, because they are typically viewed as making independent judgments in the interests of management. See, e.g., *Avon Convalescent Center, Inc.*, 200 N.L.R.B. 702 (1972).

However, often the independent judgment is simply an incident of the nursing profession, exercised in the interest of patient care, rather than for management. Under those circumstances, the nurse is not a "supervisor" in the traditional sense that term is used in non-nursing and/or industrial situations. See, e.g., *Misericordia Hosp. Medical Center*, 246 N.L.R.B. 351 (1979).

Many nurses who are also statutory supervisors belong to the ANA and its state affiliates. This presents the potential problem of disqualification of the organization from collective bargaining. See *Rockford Memorial Ass'n*, 247 N.L.R.B. 319 (1980); *Sidney Farber Cancer Institute*, 247 N.L.R.B. 1 (1980); *Sierra Vista Hosp., Inc.*, 241 N.L.R.B. 631 (1979). Member Truesdale suggests some of the problems and positions:

Another area in which the Board has struggled with the significance of supervisory status is in the health care field, where supervisory nurses often serve as officers in state nurses' associations which act as bargaining representatives for nurses. This situation is viewed by some as a potential conflict of interest. Until last year, the Board's response in such cases was to certify nurses' associations, notwithstanding the participation of supervisory nurses, so long as the association "effectively delegated its collective-bargaining authority . . . to an autonomous local unit of nonsupervisory . . . nurses." (*Sierra Vista Hospital, Inc.*, 225 NLRB 1086, 1088).

That approach found little favor with the courts. The Court of Appeals for the Fourth Circuit characterized the Board's approach as "certifying [a state nurses' association] to bargain on condition that it not bargain."

In *Sierra Vista Hospital, Inc.*, 241 NLRB No. 107, the Board reconsidered this approach and abandoned it. Rather than the conditional certification avenue, the other four Members declared their intention to require an inquiry at the representation-hearing stage into possible supervisory domination of the union. As a result, quite a few

ysis, the public will suffer the consequences of such an unfortunate outcome.

CONCLUSION

The Board's unit determinations of professional employees in the health care industry have been wise. The Board usually designates two professional units—one, consisting of registered nurses, and the other, of the residual professional employees. These determinations pay respect, a respect not legally required, to the Congressional admonition against the proliferation of bargaining units in the health care industry. The unit determinations support the policy of cost containment and the policy against unnecessary, disruptive strikes in hospitals. Moreover,

cases coming up on technical 8(a)(5) refusal-to-bargain charges were remanded for a hearing on the issue.

I dissented in *Sierra Vista* because, in my view, it was inappropriate to litigate what was essentially an unfair labor practice issue in a representation context. In my view, the proper response to supervisory participation in labor organizations is employer self-help; that is, if the employer is concerned about possible liability for domination of a labor organization, or about a possible conflict of loyalties, it can simply order its supervisors to cease their union activities. If the employer fails to do so, the only possible victims are employees, who remain free to file 8(a)(2) charges. I further observed that, to the extent that supervisors employed by other employers were members or officers of the union, any argument that this raised a conflict of interest could be litigated in a ULP proceeding. In my view, the hearings ordered by my colleagues invited employers to delay certification and bargaining while they embarked on a fishing expedition in what was almost necessarily a dry pond.

It is instructive to note the after-effects of *Sierra Vista*. To date, the mass of remanded cases have produced exactly one case in which my colleagues found a conflict of interest. In *Exeter Hospital*, 248 NLRB No. 56, Chairman Fanning and Members Jenkins and Penello found that supervisors played a "crucial role" in the petitioning union's internal affairs and, therefore, that a "clear and present danger of a conflict of interest" had been established. For this reason, they dismissed the petition, notwithstanding that the union had engaged in negotiations with the employer and that no employee objected to the union's continued status as collective bargaining representative. I was not on the panel that considered *Exeter*, but the factors considered in that case are comparable to those usually considered in unfair labor practice cases, including cases cited by the panel in *Exeter*. Thus, it seems to me that we have delayed the bargaining rights of many employees to snare one union that could have been dealt with in later ULP proceedings.

88 Daily Labor Reports (BNA) F-3, F-4 (May 5, 1980). See Note, *NLRB v. Annapolis Emergency Hospital Association: The Propriety of Conditional Certification As A Means of Avoiding Employer Domination in the Collective Bargaining Unit*, 19 WM. & MARY L. REV. 606 (1978). See also Creighton, *Law for the Nurse Supervisor: Supervisor Membership in the ANA*, 7 SUPERVISOR NURSE 48, 52 (July, 1976).

Another issue has been the ability of state nurses' associations, affiliates of the ANA, to represent registered nurses for purposes of collective bargaining where such associations maintain nurses' registries that might be seen as competitive with hospitals, in that both the registry and the hospital provide health care services. The registries maintained by the nursing associations provide nurses, presumably as independent contractors, to hospitals. This possible competition for nurses raises the issue of whether, under *Bausch & Lomb Optical Co.*, 108 NLRB 1555 (1954), the organizations should be disqualified from collective bargaining because of conflict of interest. See *NLRB Hears Conflict of Interest Argument in State Nurses' Association Bargaining Role*, 204 Daily Labor Reports A-10 (Oct. 22, 1981).

the nursing profession is united by interests not shared by other health care professionals. Nurses, when seeking separate representation, commonly choose a professional organization, such as an affiliate of the American Nurses' Association, to represent them. The professional interests of this and like organizations is directed primarily toward patient care.

Due to nursing's unique role in the delivery of health care, the bargaining representative of professional nurses should be the American Nurses Association or, in the alternative, an organization which has an identity affiliated with professional nursing. Allowing separate representation to nurses will make this result more likely. The nursing profession has unique needs regarding collective bargaining issues, and those unique needs are not only those of the profession itself, but also include the public interest in quality patient care. This dual concern mandates that an organization with those same priorities and interests represent nurse employees at the bargaining table. When nurses choose union representation, it is precisely these professional associations that are chosen by registered nurses.¹¹¹ Non-professional or industrial representation of registered nurses would mean a loss not only of adequate representation at the bargaining table, but also a decrease in the quality of patient care.***

111. See note 109 *supra*. Registered nurses choose union representation at a higher rate than employees generally. See Dworkin, Extejt, & Demming, *Unionism in Hospitals, or What's Happened Since PL 93-360?*, HEALTHCARE MANAGEMENT REV. 75, 79-80 (Fall 1980). Compared to the 46% victory record of unions nationwide in 1977, the ANA affiliates had a 72% win record, and the AFT won 86% of its white-collar elections. LaViolette, *Unions Rush Hospital Defense; Tackle Nurses*, 10 MOD. HEALTHCARE 64, 70 (Sept. 1980). Obviously, many registered nurses no longer believe that "union" is a dirty word. *Id.*

For an analysis of this organizing success rate, see Becker & Miller, *Patterns and Determinants of Union Growth in the Hospital Industry*, 2 J. LAB. RESEARCH 309 (1981). The ANA follows a reactive policy in acquiring new bargaining units. Constrained by a shortage of funds and staff such groups as ANA generally do not initiate organizing drives but rather respond to request for assistance from employees who have largely decided already that they wish to be unionized. Moreover, registered nurses historically seemed to have turned first to ANA as the appropriate organization

Id. at 323-24.

*** As this article goes to press, a sharply divided NLRB set forth new guidelines for determining appropriate bargaining units in the health care industry. St. Francis Hospital, 265 N.L.R.B. No. 120, 8 DAILY LAB. REPORTS (BNA) D-1 (Jan. 12, 1983). Members Fanning, Jenkins, and Zimmerman named seven *potentially* appropriate units: physicians, registered nurses, other professional employees, technical employees, business office clerical employees, service and maintenance employees. Chairman Van de Water and Member Hunter dissented on the basis of the Congressional admonition and the courts' repeated refusals to uphold the Board's health care industry unit determinations. This article expresses no opinion on the six additional, *potentially* appropriate units.

NOTES
&
COMMENTS

